Physician Payments

Sunshine Act

"Sunshine" is in the Forecast: Industry must begin data collection for the Physician Payments Sunshine Act, also called the Open Payments program, on Aug. 1. Review a recent webinar to find out how the law will impact you. The Centers for Medicare and Medicaid Services (CMS) has also released an app to help physicians keep track of payments from industry. Download it here.

Some important dates:
August 1 - Data collection begins
March 31 of each year - Industry reports information to CMS
September 30 - First reports made public
Reports available annually on June 30 each year following 2014.

AZ ACC Early Careers Networking Event
August 22, 2013

Join us as our guest to network with your peers and share ideas, concerns and solutions with others at the same stage of their career.

Time: 5:00 pm - 6:30 pm
Location: Searsucker
6900 East Camelback Road Scottsdale, AZ 85251
Be our guest. Admission is free!

Online Registration
Questions: annie@aminc.org or call toll free 877-460-5880.
On Efficiency, Quality and Convergence in Cardiology

In the 1970's, influential management observations by Peter Drucker and new ideas in industrial engineering described techniques to achieve efficient, quality outcomes in manufacturing. Standardization, teamwork and understanding supply chain efficiencies allowed companies such as Toyota to leapfrog their European and American competitors, at the time, winning quality awards, customers and financial success. Over time, these approaches, particularly getting things right the first time, were applied to customer service and the entire buying experience. Although others have caught up, Toyota's flagship line of Lexus automobiles ranks near the top in quality, satisfaction and perceived value.

So what does making an automobile have to do with Cardiology today? I was pondering this as we discussed “efficiency” among our group. I am in a private practice environment with a challenging business model. How do we achieve financial success and quality Cardiology care delivery in an era of declining reimbursement and the increasing costs of doing business? We highlighted the practices of the most efficient doctors in our practice – those who could generate the most revenue per unit of time. As our procedural reimbursement has declined, the most efficient providers may not be those in the hospital setting, but rather those with active office practices. The hospital slows you down. There are families to talk to, messy histories to verify, the lack of accessible data points to clarify a diagnosis and the waiting, waiting, waiting for tests results to make a clinical decision. All of this and the need to follow up test results at the end of the day take away precious minutes from your personal life. From a financial and efficiency standpoint, the hospital is unpredictable, the supply chain of patients unreliable, the manufacturing processes of diagnosis, treatment and outcomes variable and the quality of care dependent upon a host of factors over which we may have no input or oversight.

The office side of our practice is at least more predictable – if you can keep the primary care referral sources happy then you can maximize the supply of patients, work hard on providing services to as many patients as possible in a timely fashion and thus improve your revenue stream. Tests can be ordered and the patient seen at a follow up visit for review. Questions that might be answered with a phone call can be scheduled as office visits. One problem can be addressed in an office visit and have the patient return in a couple of weeks for the next issue. New patients are preferred; they pay more, as are simple consults that require a couple of tests. All of these strategies generate revenue - which is no small feat given the financial pressures on private practice these days. But even the most “efficient” among us would admit that some of the revenue generating practice patterns might not be the most efficient on a macro-economic level.

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CMS, state Medicaid programs and major insurance companies are all promulgating regulations and procedures to maximize their own efficiency. Whether it is trying to squeeze out as much service as you can in a Medicare population or providing a return on investment to shareholders, payors view efficiency in a different light than we do as providers. Increased cost-sharing, restrictive formulary decisions, prior authorizations and denial of services may be viewed as reasonable approaches to limit costs and improve financial efficiency, but we find them burdensome and detrimental to running efficient business practices. Hospitals have their own set of financial and efficiency goals. In a DRG-driven world, reducing length of stay and utilization costs are the keys to financial survival. In the fee-for-service landscape, maximizing the number of tests still pays the bills - think lab services, monitoring, chest CTA and stress myocardial perfusion scanning for a young chest pain patient.

At the end of the day, efficiency depends upon where you are standing in the healthcare delivery arena. Sometimes the worst place to stand is in the patient’s shoes. Physicians, hospitals and payors have goals that are at odds with one another. In our practice, we have had insurers deny cardiac catheterization for patients who subsequently had a, presumably preventable, myocardial infarction. Others who had complete workups for atypical chest pain as an outpatient ended up in a hospital with a six-figure charge to the insurance carrier due to the repetition of tests (see Steven Brill’s article, “Bitter Pill: Why Medical Bills Are Killing Us” in Time Magazine). In fairness, even we are guilty at times of encouraging return visits or tests that might be of questionable necessity.

And so we have come to a crossroads in healthcare in general– and Cardiology in particular. At times it feels like the ACA and general market forces have conspired to decrease our value, at least in a financial sense. At the same time, our value to individual patients and the health care system in general is enormous. We are both blessed and burdened with daily life-altering decisions. We manage disease across a lifetime and across a large swath of the medical landscape with heart failure, atherosclerosis risk factor management, chronic arrhythmias and other long-term health issues. Our practice patterns affect the health of individual lives and the health of the system.

So what is the answer to this dilemma? How do we maximize efficiency for the physician, the payors, the hospital and healthcare networks and the patients? We desperately need systems that provide us the right information at the right time to make the right decisions in care. Do we join forces and integrate with hospitals, networks, ACO’s, insurance companies? How do we foster integration without putting our patients and ourselves in silos that may limit access to innovative and effective subspecialty care?

These are the questions with which the ACC is struggling at a national level as we prepare a strategic plan for the future. Many of us are struggling with these issues in Arizona as well. We have invited Dr. Matt Phillips of Austin Heart to speak to our Arizona ACC chapter on October 10 in Scottsdale. Austin Heart is a group that works hard to understand the efficiency of their practice, and Dr. Phillips will bring his insights into the trends of practice integration in Texas and nationally. Please join us for what should be an enlightening presentation and a lively conversation. Bring your questions, wisdom and insights. With your participation we can learn from each other and begin to solve some of these challenges together. As always, I welcome your comments and questions.
I can be reached at craighoovermd@gmail.com.
Navigate PQRS Rules with ACC’s 2013 Primer
In 2015, CMS will penalize physicians who do not participate in the Physician Quality Reporting System (PQRS) in 2013. It’s time for cardiologists to make an informed decision about how best to begin participating or make some changes to how they participate in PQRS in 2013 and beyond. Navigate new PQRS rules with ACC’s 2013 PQRS Primer. Questions? Contact vbp@acc.org.

Reimbursement Change on the Horizon
Starting on July 1, the Centers for Medicare and Medicaid Services (CMS) now require claims including CPT codes for transcatheter aortic valve replacement (TAVR) (0256T, 0257T, 0258T, 0259T, 33361, 33362, 33363, 33364, 33365 and 0318T) to contain the following before they will issue reimbursement:

- Clinical trial registry number (an eight digit number preceded by "CT")
- Q0 modifier
- Secondary diagnosis code of V70.7 (examination of participant in clinical trial)

For more information, click here.

CMS Releases Proposed 2014 Medicare Physician Fee Schedule
The Centers for Medicare and Medicaid Services (CMS) has released two proposed rules with important ramifications for cardiovascular professionals. These rules address Medicare payment and quality provisions for physicians and hospital outpatient services in 2014. The rules indicate that physicians will receive a more than 22 percent decrease in 2014 as a result of the legally mandated Sustainable Growth Rate (SGR) and that hospitals will receive a 1.8 percent increase in payment. As in previous years, the ACC continues to fight to avoid the physician payment cut. Aside from the across-the-board cuts associated with the SGR, CMS estimates that the physician rule will increase payments by 2 percent to cardiologists between 2013 and 2014. This estimate is based on typical practice and can vary widely depending on the mix of services provided in a practice. Read some of the other most important proposals for cardiology contained in the rules in the July 8 issue of the Advocate here. More details will be posted on Cardiosource.org.
ACC Legislative Conference: September 22-24
Heart House on the Hill

Pulitzer Prize-winning reporter Bob Woodward will kick off the ACC’s 2013 Legislative Conference on Sunday, Sept. 22 at 6:30 p.m. at the Fairmont Hotel in Washington, DC. Woodward will deliver the keynote remarks during the annual ACC Political Action Committee (PAC)-sponsored dinner. His speech, titled “Presidential Leadership and the Price of Politics,” will be the centerpiece of a fascinating and thought-provoking evening. Register for the conference by clicking here and reserve your dinner tickets by contacting Lucas Sanders at lsanders@acc.org.

Check out the ACC in Touch Blog
Check out the newly revamped ACC in TouchBlog at blog.cardiosource.org for multiple posts each week on hot topics.

Here are some of the hottest posts from the end of last month – although there are many more from earlier in the month:

• A June 27 post by Mary Norine Walsh, MD, FACC focuses on accreditation of advanced heart failure and transplantation cardiology.
• A June 17 post by BOG Chair David May, MD, FACC explores the much needed relationship and collaboration within the house of cardiology.

And many more!

UPCOMING EVENTS
Check out our website at www.acc-az.org for details on all events.

August:
2nd-4th: Cardiology Update 2013: The Heart of the Matter, Enchantment Resort, Sedona
22nd: Early Careers Networking Event, Searsucker, Scottsdale

September:
22nd-24th: 2013 ACC Annual Legislative Conference, Washington D.C.
27th-29th: Phoenix Heart 2013 Symposium “Bridging the Gap”, JW Marriott Desert Ridge Resort & Spa, Phoenix

October:
4th-5th: Cardiovascular Disease Management: A Case-Based Approach, Arizona Biltmore Hotel, Phoenix
27th-Nov. 1st: TCT 25 Conference: Reinventing the Future Every Year, Moscone Center, San Francisco